# Contents


| | | Page | |
|---|---|---|---|
| DIGEST | | i | 1/A5 |
| CHAPTER | | | |
| 1 | INTRODUCTION | 1 | 1/A11 |
| | The Medicaid program | 1 | 1/A11 |
| | State Medicaid fraud control units | 2 | 1/A12 |
| | Participating States | 3 | 1/A13 |
| | Nonparticipating States | 3 | 1/A13 |
| | HHS administration | 4 | 1/A14 |
| | Objectives, scope, and methodology | 4 | 1/A14 |
| 2 | STATE FRAUD UNITS CAN BE EFFECTIVE, BUT MAY NOT BECOME SELF-SUPPORTING | 7 | 1/B3 |
| | Cost of and potential recoveries from fraud unit operations | 8 | 1/B4 |
| | Increased fraud investigation and prosecution as a result of Public Law 95-142 | 11 | 1/B7 |
| | Fraud unit deterrent effects and other contributions | 14 | 1/B10 |
| | Proposed continued funding for fraud units | 18 | 1/B14 |
| | Conclusions | 19 | 1/C1 |
| | Recommendations to the Secretary of HHS | 20 | 1/C2 |
| | Recommendation to the Congress | 20 | 1/C2 |
| | HHS and fraud unit comments and our evaluation | 20 | 1/C2 |
| 3 | BETTER REFERRALS FROM AND COOPERATION WITH STATE MEDICAID AGENCIES NEEDED | 22 | 1/C4 |
| | Memorandum of understanding | 22 | 1/C4 |
| | States did not provide adequately developed referrals | 23 | 1/C5 |
| | Cooperation between fraud units and State Medicaid agencies | 30 | 1/C12 |
| | Conclusions | 32 | 1/C14 |
| | Recommendation to the Secretary of HHS | 32 | 1/C14 |
| | HHS comments | 32 | 1/C14 |
| 4 | PROBLEMS IN HIRING, RETAINING, AND TRAINING FRAUD UNIT PERSONNEL | 34 | 1/D2 |
| | Hiring and retaining fraud unit staff | 35 | 1/D3 |

| CHAPTER | | Page | |
|---|---|---|---|
| | Staff training and supervision | 39 | 1/D7 |
| | Conclusions | 43 | 1/D11 |
| | Recommendation to the Secretary of HHS | 43 | 1/D11 |
| | HHS comments | 43 | 1/D11 |
| 5 | PROBLEMS IN ASSURING STATEWIDE PROSECUTION CAPABILITY | 44 | 1/D12 |
| | Certification requirements | 44 | 1/D12 |
| | Need to clarify type of formal procedures to be established | 46 | 1/D14 |
| | Extent of problems in statewide prosecution | 47 | 1/E1 |
| | Conclusions | 51 | 1/E5 |
| | Recommendations to the Secretary of HHS | 51 | 1/E5 |
| | HHS comments and our evaluation | 52 | 1/E6 |
| APPENDIX | | | |
| I | Expenditures and potential recoveries of State Medicaid fraud control units since their effective certification dates through December 31, 1979 | 54 | 1/E8 |
| II | Letter dated August 8, 1980, from the Inspector General (Designate), Department of Health and Human Services | 55 | 1/E9 |


ABBREVIATIONS

| | |
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| GAO | General Accounting Office |
| HCFA | Health Care Financing Administration |
| HHS | Department of Health and Human Services |
| MMIS | Medicaid Management Information System |
| OIG | Office of the Inspector General |

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OCT 8 1980

BY THE COMPTROLLER GENERAL

# Report To The Congress

OF THE UNITED STATES

COMPLETED

ORIGINAL

# Federal Funding For State Medicaid Fraud Control Units Still Needed

State Medicaid fraud units, established after Federal support for such units was increased to 90 percent of their costs for fiscal years 1978-80, have increased States' ability to investigate and prosecute Medicaid fraud. However, the units have not become self-supporting as anticipated.

The 27 fraud control units operating as of December 31, 1979, had identified potentially recoverable amounts equal to only about one-half their operating costs. GAO believes the goal of the units becoming self-supporting after September 30, 1980, will be extremely difficult to achieve. According to unit officials, if some Federal funding is not continued, many units likely will cease to exist or will operate less effectively.

The Congress should fund the units beyond September 1980. However, to receive such funding, units should have to demonstrate effective performance based on reasonable standards established by the Department of Health and Human Services.

HRD-81-2
OCTOBER 6, 1980

68

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-200370

To the President of the Senate and the
Speaker of the House of Representatives

This report discusses the effectiveness of State Medicaid fraud control units and the actions that the Department of Health and Human Services should take to improve program operation and administration. We made this review to determine whether the establishment and operation of these units has increased the States' ability to investigate and prosecute Medicaid fraud.

We are sending copies of this report to the Director, Office of Management and Budget, and the Secretary of Health and Human Services.

Comptroller General
of the United States

A

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

# FEDERAL FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS STILL NEEDED

## D I G E S T

Medicaid fraud costs American taxpayers millions of dollars annually. To help reduce these losses, the Congress in 1977 enacted the Medicare-Medicaid Anti-Fraud and Abuse Amendments authorizing 90-percent Federal matching payments, instead of the normal 50, for fiscal years 1978-80 as an incentive to States to establish Medicaid fraud control units.

It was expected that this financial relief would enable many State governments to establish new units or expand existing ones and that, after the units had been in operation a few years, they would begin to recover from prosecutions amounts equal to or exceeding their operating costs. Most units have not been able to identify and collect more fraudulent overpayments than their operating costs. Those that have may have difficulty continuing to do so unless some Federal funding is continued.

### FRAUD UNITS CAN BE EFFECTIVE; FEDERAL FUNDING SHOULD CONTINUE

The Department of Health and Human Services' (HHS') Office of the Inspector General is responsible for certifying, funding, and monitoring the fraud control units. 1/ As of April 30, 1980, 30 States and the District of Columbia had certified fraud units. GAO reviewed seven.

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1/Effective May 4, 1980, the Department of Education formally commenced operations. Before that date, activities discussed in this report were the responsibility of the Department of Health, Education, and Welfare.

Tear Sheet. Upon removal, the report cover date should be noted hereon.

At the time of GAO's fieldwork, 27 units had been certified. From their effective certification dates through December 31, 1979, these units reported potential recoveries of about $19 million--about one-half their total operating costs of $36 million. However, the accuracy of the recoverable amount is questionable because three of seven units GAO reviewed reported incorrect amounts. Additionally, five of the seven units did not maintain information on the amount of the overpayments identified for recovery that had actually been collected. GAO believes it will be extremely difficult for State fraud units to become self-supporting after September 30, 1980. (See p. 8.)

Although most fraud units may not become self-supporting, they have increased States' ability to investigate and prosecute Medicaid fraud. The additional Federal funding has resulted in increases in the number of staff, cases handled, and convictions. (See p. 11.) Fraud units also deter Medicaid providers from attempting fraud and have had an impact on changing State legislation and Medicaid regulations to make it easier to identify fraud and provide for more stringent penalties. (See p. 14.)

GAO believes that fraud units can be an effective force in combating Medicaid fraud and that their effectiveness should increase as they gain experience in investigating and prosecuting Medicaid fraud.

On April 23, 1980, the House Committee on Interstate and Foreign Commerce reported H.R. 4000, the Medicare and Medicaid Amendments of 1980. The bill authorizes Federal matching payments to States for establishing and operating Medicaid fraud control units at the rate of 90 percent for the first 3 years and 75 percent thereafter. This provision was included as section 336 of H.R. 7765, the Omnibus Reconciliation Act of 1980, which passed the House on September 4, 1980. (See p. 18.)

Many officials connected with fraud units believe that, if some type of continued Federal funding is not provided, many units will cease to exist or operate at a reduced level of effectiveness. Also, the establishment of fraud units in other States is unlikely unless Federal funding is extended beyond September 1980. (See pp. 18 and 38.)

RECOMMENDATION TO THE CONGRESS

The Congress should provide for funding State Medicaid fraud control units beyond September 1980. Such legislation should require HHS to annually certify for continued funding only those units that have demonstrated effective performance based on reasonable performance standards established by HHS. (See p. 20.)

HINDRANCES TO MORE EFFECTIVE OPERATION OF FRAUD UNITS

A number of situations hinder effective operation of the State fraud units:

--Potential fraud cases referred to the units have generally not contained sufficient information to make a meaningful evaluation of fraud prosecution potential. (See p. 23.)

--Investigations have been hampered by problems in their dealings with State Medicaid agencies. Mutual distrust, concern over loss of control of fraud investigations, and personality conflicts contribute to this situation. (See p. 30.)

--Fraud units have experienced problems in hiring and retaining qualified staff due to (1) low State salaries for auditors, investigators, and attorneys, (2) State budget constraints affecting available funds and personnel ceilings, and (3) the uncertainty of Federal funding after September 1980. (See p. 35.)

--Fraud unit staff have not received adequate training. The Office of the Inspector General can further assist the units in training staff. (See p. 40.)

Two fraud units GAO reviewed did not implement the formal procedures HHS had approved to assure prosecution of suspected Medicaid fraud cases on a statewide basis. Another unit did not initially provide for effective coordination between the unit and the attorney general's office for prosecution of Medicaid fraud. (See p. 47.)

RECOMMENDATIONS TO HHS

The Secretary should direct the HHS Inspector General to:

--Verify, on a sample basis, the accuracy of the statistics contained in the State fraud units' quarterly reports on their fraud investigation activities. (See p. 20.)

--Determine which fraud units do not have adequate procedures for following up on the amount of overpayments actually collected and require them to establish appropriate procedures. (See p. 20.)

--Develop criteria, in consultation with fraud units and State Medicaid agencies, to guide Medicaid agencies on the extent to which a potential fraud case should be developed before referral to a fraud unit and the types of data and analysis that should be included. (See p. 32.)

--Develop a fraud unit training manual incorporating the most effective techniques and methods identified by the units for dealing with Medicaid provider fraud. (See p. 43.)

--Reassess the adequacy of arrangements now in effect in States where the attorney general's office does not have statewide prosecution authority, or if it does, the unit is located outside that office to

assure that prosecution can be carried out as needed statewide. (See p. 52.)

--Decertify State fraud units that fail to meet the statewide prosecution requirement of the law and regulations. (See p. 52.)

--Issue guidelines on essential elements that should be included in a fraud unit's formal procedures with local prosecutors or working relationships with the State attorney general to assure statewide prosecution. (See p. 52.)

HHS AND STATE COMMENTS

HHS and four of the seven State fraud units GAO reviewed commented on a draft of this report. The fraud units commented essentially on statements in the report relating to their particular unit, and their comments are incorporated where appropriate.

HHS generally concurred with GAO's recommendations. It said that:

--The accuracy of the statistics contained in fraud units' quarterly reports and the adequacy of the units' procedures for following up on the amount of overpayments actually collected will be reviewed during onsite recertification visits. (See p. 20.)

--A model memorandum of understanding between State Medicaid agencies and fraud units has been developed which will include criteria for referral of potential fraud cases. GAO also noted that proposed revisions to the Federal regulations would require that the memorandum include criteria and formats for the referral of cases. (See p. 32.)

--A fraud unit training manual will be developed as additional staff are added to the division administering the program. (See p. 43.)

--The proposed revisions to the Federal regulations contain requirements relating to the type of formal procedures that fraud units must establish with local prosecutors to assure statewide prosecution of fraud cases. (See p. 52.)

GAO believes that, if the revised regulations are adopted and the other above actions are taken, they will satisfy the intent of its recommendations.

HHS disagreed with the position GAO took in a draft of this report pertaining to the type of formal procedures that fraud units are required to establish to assure statewide prosecution of fraud cases. GAO has clarified its position in this report. (See p. 52.)

# CHAPTER 1

## INTRODUCTION

Section 17 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) authorized 90-percent Federal matching payments for fiscal years 1978-80 for establishing and operating (including the training of personnel) State Medicaid fraud control units. These units were authorized by the Congress as a result of its concern that sufficient efforts had not been made to investigate and prosecute cases of Medicaid fraud--possibly because of the fiscal restraints imposed by a 50-percent Federal administrative matching formula which restricted the establishment or expansion of such units.

## THE MEDICAID PROGRAM

Medicaid--authorized by title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to persons unable to pay for such care. Based on per capita income in the State, the Federal Government pays from 50 to 78 percent of the States' costs for medical services under the program. The Medicaid program began January 1, 1966.

Services provided to Medicaid recipients vary among States. As a minimum, States participating in Medicaid must provide the following services: physician; inpatient and outpatient hospital; laboratory and X-ray; skilled nursing home; home health care; family planning; rural health clinic; and early and periodic screening, diagnosis and treatment of eligible individuals under age 21. Additional services, such as dental care and prescribed drugs, may be included under a Medicaid program at a State's option.

Each State designs and administers its Medicaid program and prepares the State Medicaid plan, which is the basis for Federal cost sharing. The Department of Health and Human Services' (HHS') 1/ Health Care Financing Administration (HCFA) approves State plans that meet Federal requirements. It monitors State Medicaid operations to see that they conform to Federal requirements and the approved State plan.

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1/On May 4, 1980, the Department of Education formally commenced operations. Before this time, HCFA was a part of the Department of Health, Education, and Welfare.

The costs of providing health care under Medicaid have increased greatly since the program began. In fiscal year 1967, the Federal and State cost of providing Medicaid services was about $2.3 billion. By fiscal year 1979, the cost had risen to about $19.7 billion nationwide.

## STATE MEDICAID FRAUD CONTROL UNITS

Medicaid fraud costs the American taxpayer millions of dollars annually. Much attention has been focused on Medicaid fraud and abuse by newspapers, magazine articles, congressional hearings, and television. The following lists some reported Medicaid fraud schemes:

--Kickbacks by laboratories and pharmacies to physicians and nursing homes, respectively, for Medicaid business.

--Billings by physicians for services not rendered.

--Charging for more expensive services than those actually rendered.

Because Medicaid fraud losses were threatening the integrity of the Medicaid program, the Congress in 1977 took a major step to help bring such losses under control. Public Law 95-142, which became effective October 25, 1977, authorized 90-percent Federal matching payments for establishing and operating State Medicaid fraud control units for up to a 3-year period ending September 30, 1980. The law and regulations require that the applicant States meet several requirements to be eligible for the 90-percent matching rate. Most notably, the unit must:

--Not only have the capability to investigate potential Medicaid fraud but also the ability to prosecute cases on a statewide basis, or have assured access to such prosecutive ability.

--Remain separate and distinct from the "single State agency" that administers the Medicaid program.

--Review complaints of alleged abuse and neglect of patients in health care facilities receiving payments under the State Medicaid plan and, where appropriate, act on such complaints or refer them to appropriate State agencies for action.

--Provide for the collection, or referral to the appropriate State agency for collection, of overpayments it identifies as having been made to health care facilities or other providers of medical assistance under the State Medicaid plan.

--(1) Be a part of the State attorney general's office or other department of government that possesses statewide criminal prosecuting authority, (2) have formal procedures for referral of cases to local prosecutors, if the State constitution does not give the attorney general or other department of government statewide criminal prosecuting authority, or (3) have a formal working relationship with the attorney general and formal procedures for referring cases to him.

It was expected that, with the financial relief afforded State governments by the 90-percent matching formula, many States would be able to establish fraud control units or expand existing efforts and that, after these units had been in operation for a few years, their recoveries from prosecutions should begin to equal or exceed their operating costs. Therefore, the 90-percent matching formula was authorized for 3 years.

## PARTICIPATING STATES

As of April 30, 1980, 30 States and the District of Columbia had certified Medicaid fraud control units. Nebraska originally participated in the program but was terminated in January 1980 for failing to meet the requirements of the law. The certified units are in States that spend about 80 percent of the Federal Medicaid dollars. At the time of our fieldwork in December 1979, 27 States had certified fraud units. A list of these State fraud units showing their total expenditures and reported potential recoveries is contained in appendix I.

## NONPARTICIPATING STATES

Nineteen States were not participating in the program as of April 30, 1980, although some States had their own investigative units that investigated fraudulent Medicaid providers. According to a survey conducted in May 1979 by HHS' Office of Inspector General (OIG), the States' reasons for not participating were as follows:

--Eight States had an active fraud unit, which was part of the State Medicaid agency. These States had indicated that they wanted to keep the unit within the Medicaid agency, which would not meet the requirement for the unit to be separate and distinct from the single State agency.

--Six States were not interested in establishing a fraud unit because they believed that very little Medicaid fraud existed in their States.

--Four States had an active fraud unit in various segments of their State governments and were not interested in participating in the program.

--One State (Arizona) does not participate in the Medicaid program.

## HHS ADMINISTRATION

Because fraud control units are paid from Medicaid funds, HCFA was originally given the certification and recertification responsibility and performed that role with assistance from OIG. However, as of April 15, 1979, the certification, recertification, and continuing oversight responsibility was transferred to OIG because fraud unit responsibilities of investigation and prosecution are more closely related to OIG than to HCFA. OIG also assumed the responsibility for tracking fraud control units' progress regarding casework performance and overpayments identified.

Since OIG assumed responsibility for administering the program, it has recertified most of the active State fraud units for their later years of operation. As a part of its recertification process, OIG reviews the State fraud units' applications for recertification and makes onsite visits to each unit to observe operations. It also collects and analyzes statistical data on the number of cases under investigation; the number of convictions obtained; and the amount of potential recoveries, including fines and penalties.

## OBJECTIVES, SCOPE, AND METHODOLOGY

We made our review because of congressional interest in the performance and effectiveness of the States' fraud units and because it was likely that legislation would be proposed

to extend the Federal funding for fraud units beyond September 1980. The primary objectives of our review were to determine whether:

--HHS certified for 90-percent Federal funding only those fraud units that met the requirements of the law and implementing regulations.

--The establishment and operation of fraud units had increased the States' ability to investigate and prosecute Medicaid fraud.

--The fraud units were likely to become self-supporting, whereby their recoveries from prosecution would equal or exceed their operating costs as contemplated in the enabling legislation.

--Any problems were inhibiting fraud unit effectiveness.

Our review was made at OIG in Washington, D.C., and at the State Medicaid fraud control units in Illinois, Louisiana, Massachusetts, New York, Ohio, Pennsylvania, and Washington. In selecting the States to be included in our review, we considered only States whose units had been in operation for over 1 year so that, hopefully, sufficient data would be available to assess the units' effectiveness. From the States that met this criterion, we made the selection to include (1) fraud units certified by HHS under each of the three options provided for in the statute and regulations pertaining to the organizational location of the unit within the State, (2) a mix of small, medium, and large fraud units, (3) units considered to be effective as well as those considered not so effective, and (4) geographic coverage of the Nation.

In the States included in our review, we:

--Reviewed the fraud units' applications and supporting documentation to determine if the units had met the certification requirements of the regulations.

--Reviewed and verified the accuracy of the statistics contained in quarterly reports submitted by the fraud units to HHS on their fraud investigation activities. These reports are used by HHS in judging the impact the units have on Medicaid fraud.

--Obtained information from the fraud units on the number of staff, cases handled, and convictions obtained before and after their certification to determine the degree to which their participation in the program had increased States' ability to investigate and prosecute Medicaid fraud.

--Obtained and verified information reported by the fraud units to HHS on their expenditures and potential recoveries to determine the extent to which each was self-supporting. We also obtained this information for the fraud units not included in our review, but did not verify its accuracy. (See app. I.)

In addition to obtaining information from the fraud units on such indicators of effectiveness as potential dollar recoveries and number of convictions, we also obtained information on other indicators of effectiveness, such as their contributions to changes in State legislation and Medicaid regulations. These accomplishments and their impact are discussed in chapter 2.

We also obtained the views of fraud unit officials on problems which have adversely affected unit effectiveness.

## CHAPTER 2

## STATE FRAUD UNITS CAN BE EFFECTIVE BUT MAY NOT BECOME SELF-SUPPORTING

Most State Medicaid fraud control units have not become self-supporting, whereby they identify and collect more fraudulent overpayments than their operating costs. Only 6 of the 27 units had been self-supporting since their effective certification dates through December 31, 1979. Even the New York unit, which is the largest and one of the units that has been in operation the longest, has not been self-supporting. In our opinion, the goal of fraud units becoming self-supporting after September 30, 1980 (the date 90-percent Federal funding ends), will be difficult, if not impossible, to achieve.

Public Law 95-142 has increased the States' ability to investigate and prosecute Medicaid fraud. The additional Federal funding has resulted in increases in the number of staff, cases handled, and convictions. Also, there are other ways in which fraud units affect Medicaid fraud prevention. One of the most significant ways may well be the deterrent effects the units create; that is, their very existence dissuades Medicaid providers from attempting fraud. Another important impact is their contributions to changing, or attempting to change, State legislation and Medicaid regulations. The changes have made it easier to identify fraud and provide for more stringent penalties. Also, the fraud units have identified weaknesses in their State Medicaid agencies' systems and made recommendations to correct ineffective program regulations and to establish regulations where needed.

The combined effect of all these benefits could outweigh the units' cost of operations. Therefore, fraud units can be an effective force in combating Medicaid fraud. However, unless some type of continued Federal funding is provided, many fraud units are likely to cease to exist or operate at a reduced level of effectiveness. Legislation has been introduced in the Congress to extend the Federal funding for fraud units beyond September 1980.

## COST OF AND POTENTIAL RECOVERIES FROM FRAUD UNIT OPERATIONS

The 27 fraud units had spent about $36 million since their effective certification dates through December 31, 1979. During this period, the units had reported to HHS potential recoveries consisting of fines and penalties, restitutions ordered, and overpayments established of about $19 million. (See app. I.) Thus, the units' reported potential recoveries equaled about one-half of their total operating costs. However, as discussed later, two units we reviewed overstated their recoveries, and one unit understated its recoveries, which cast doubt on the validity of the amount of reported recoveries for fraud units.

Federal regulations require the fraud unit to include in its annual report to HHS information on (1) the number of recovery actions initiated by the unit and by the State Medicaid agency or other State agency that handles recovery based on overpayment cases referred from the unit and (2) the total amount recovered by the unit and by the State agency. Five of the seven fraud units we reviewed did not maintain information on the amount of the overpayments identified for recovery that had actually been collected by the unit and/or the State Medicaid agency. Therefore, we were unable to determine the amount of funds actually recovered to help defray the units' operating costs.

Not all of the fraud units have been in operation for the same length of time. Several units have been certified rather recently and have not had time to become fully operational. Even those units certified early in the program have had problems in becoming fully operational. On this point, the quarterly report of OIG for July through September 1979 states:

> "* * * new Units have taken a long time to apply for and achieve certification and then become operational. * * * many States that now have Units were slow in obtaining necessary State approvals for the application. Even today, the typical Unit is hardly more than a year old. Only three States were certified in the first six months after the enactment of the statute, even though HEW published the necessary regulations within three months after enactment. There were serious problems in many States in finding qualified people willing to work

for the often low salaries allowed by State law. These individuals frequently needed major training and orientation--in specific problems of Medicaid, in white-collar or financial-crime investigations, in large scale fraud-oriented audits of institutions, and in special problems of Medicaid prosecutions."

Many problems cited in the OIG report and discussed in other chapters of this report have contributed to the inability of the units to become self-supporting.

The fraud unit directors in some States we reviewed believed that their units, and all fraud units, would have a difficult, if not impossible, time becoming self-supporting and remaining so on a continuing basis. Some of their specific reasons for this position were as follows:

--Ohio unit officials said that they did not prosecute cases based on the potential dollar recovery, but rather on the likelihood of obtaining a speedy conviction, and consequently establishing a reputation with Medicaid providers. They believed that a publicized conviction would more effectively deter potential fraud. Also, they had not set a minimum dollar amount for cases to pursue.

--Washington unit officials believed that it was unreasonable to expect fraud units to become self-supporting because their function is criminal investigation and prosecution and their real effectiveness is as a deterrent to future crime.

--The Massachusetts unit director emphasized that fraud units should not lose sight of their primary responsibilities as law enforcement agencies. Therefore, like other law enforcement agencies, such as the Federal Bureau of Investigation, fraud units must not look upon recoveries as a yardstick of their effectiveness.

Over- and understated recoveries

Of the seven State fraud units reviewed, two units (Massachusetts and Washington) overstated the amount of their recoveries, and one unit (Louisiana) understated the amount of its recoveries.

The understatement occurred because of an oversight when the unit calculated its recoveries. Examples of the overpayment situations are as follows:

--In connection with a nursing home case, the Washington unit included $127,000 under the heading "Judicial Fines and Penalties." Although the provider was convicted and fined $15,000, the court did not order Medicaid restitution. Accordingly, the State pursued restitution through civil actions. However, while audit reports identified $127,000 in overpayments, the State negotiated a settlement for about $27,000.

--The Washington unit included $312,704, representing 37 nursing home cases, as a recovery under the heading "Judicial Fines and Penalties--Overpayment Established." According to the State's Office of Nursing Home Affairs, the $312,704 was not an overpayment, but amounts paid to nursing homes on prospective rates that were based on unaudited costs. These amounts were later adjusted based on audited costs and negotiated settlements.

--In another case a patient alleged that a provider billed Medicaid for $723, even though an insurance company paid most of these costs. The Washington unit's investigator found that (1) no fraud was involved and (2) the State, through its normal third-party collection activities, had recovered the entire $723 several months before the case had been referred to the unit. Nevertheless, the unit reported the amount as an overpayment recovery.

--In the same unit we could find no support for $261,620 of claimed recoveries. We were told that no support was available because some cases were counted twice. Consequently, an overpayment was counted once when the case was sent to the prosecutor and again when the case was closed.

--The Massachusetts unit included, in its recoveries during its first quarter of operations, $732,766 which actually resulted from several nursing homes being indicted for failure to pay State withholding taxes and unemployment contributions. The unit director believes that this amount is a valid recovery because the investigations were conducted with the objective

of discovering fraud and the unit actually collected the amount. We do not believe the amount can be considered as a Medicaid fraud related recovery.

State fraud units report quarterly to HHS on their fraud investigation activities, including overpayments established. The statistics contained in the reports, which represent the accomplishments of fraud units, are used by the Congress, HHS, and the public to judge the impact fraud units have on Medicaid fraud. Therefore, it is important that such statistics reflect as accurately as possible the performance of the fraud units. OIG officials told us that they had not attempted to systematically verify the statistics included in the quarterly reports from the State fraud units due to a lack of staff to perform such verification.

## INCREASED FRAUD INVESTIGATION AND PROSECUTION AS A RESULT OF PUBLIC LAW 95-142

Before enactment of Public Law 95-142, the investigation and prosecution of fraud in the Medicaid program was sporadic throughout the participating States. Some States established small units or task forces to investigate the growing number of allegations of Medicaid fraud. Other States did little or nothing in the area.

Since the enactment of Public Law 95-142, there has been a marked increase in the investigation and prosecution of Medicaid fraud. In November 1979, OIG reported that there were about 2,400 cases under investigation as of June 30, 1979. At that time, 157 firms or individuals had been indicted or charged with fraud, and 125 convictions had been obtained. These statistics were for the 27 certified State fraud units that had an authorized total of 782 professional staff--388 investigators, 220 auditors, and 174 attorneys. The New York unit was operating under a New York State Executive Law before enactment of Public Law 95-142; its level of investigation and prosecution did not increase dramatically. The other State units we reviewed have increased their investigation and prosecution activities as follows:

### Washington

HHS certified the Washington fraud unit in July 1978, retroactive to April 1978. In Washington, no agency has statewide authority and capability for criminal fraud prosecution. The additional Federal funding resulted in a two- to threefold increase in the number of staff, cases handled,

and convictions. In February 1974 the State began a program for investigating Medicaid fraud. Before certification, the State had special investigators who worked with the local prosecutors to obtain convictions. This unit handled an average of 5.7 cases per month and had five investigators. As of December 31, 1979, the unit handled 14.9 cases per month and had nine investigators, four auditors, and two attorneys. In the 52-month period before certification, the State obtained 14 convictions. Since certification through December 31, 1979 (18 months), the fraud unit's efforts had resulted in 12 convictions.

Massachusetts

HHS certified the Massachusetts fraud unit in August 1978, retroactive to July 1978. In Massachusetts, the attorney general has statewide authority for criminal fraud prosecution. The Massachusetts attorney general initiated a nursing home task force in February 1977 with a staff of 10 people who investigated and prosecuted nursing home fraud until the certification of the fraud unit.

The task force became involved in Massachusetts' first nursing home fraud case and later looked into nursing home fraud involving overbilling, payroll padding, misuse of patients' personal funds, and understatement of patient days. As a result of the task force's efforts, an owner of 11 nursing homes was indicted and convicted of stealing $313,854 of the taxpayers' money. Another owner of four nursing homes was convicted of larceny in the amount of $33,260 and was fined $41,010. During the task force's initial year of operation, 19 nursing homes were investigated, and the owners of all 19 homes were convicted of fraud against the State.

After certification, the unit expanded the activities of the task force to dentists, doctors, pharmacists, and ambulatory services. To meet the increased caseload and responsibilities, the staff was increased from 10 to 69--57 professional and 12 administrative--as of December 31, 1979. Since certification through December 31, 1979, the unit's efforts had resulted in 17 convictions.

Louisiana

HHS certified the Louisiana fraud unit in March 1978. In Louisiana, no agency has statewide authority and capability for criminal fraud prosecution. Before certification, there was no fraud control unit in Louisiana. The State's

only Medicaid fraud detection effort was in the State Medicaid agency and consisted of two staff members who attempted primarily to detect recipient fraud rather than provider fraud. Since certification, the fraud unit had grown to a staff of 14, including 2 prosecutors, 9 investigators, and 3 clerks, as of December 31, 1979. At that time, the unit had 68 active cases in various stages of investigation, and its efforts had resulted in 1 conviction.

Pennsylvania

HHS certified the Pennsylvania fraud unit in August 1978, retroactive to January 1978. No agency in Pennsylvania has statewide authority and capability for criminal fraud prosecution. Before certification of the fraud unit, the Pennsylvania welfare department's special investigation unit was responsible for investigating provider fraud and abuse and was instrumental in obtaining nine convictions and $63,242 in restitution between July 1976 and May 1978. This investigative unit had 17 members and, in addition to Medicaid fraud, it was responsible for investigations involving public assistance, food stamps, State employee activity, and contractor activity. Because the unit had no prosecutory power, cases were taken to district attorneys or to the U.S. attorney for prosecution.

Since certification, the fraud unit has been increased to 40 persons, including attorneys, investigators, and auditors. As of December 31, 1979, the unit was investigating 54 cases, and its efforts had resulted in 4 convictions.

Ohio

HHS certified the Ohio fraud unit in September 1978, retroactive to April 1978. The Ohio attorney general has statewide authority for criminal fraud prosecution. Medicaid fraud investigation began in Ohio about 18 months before the fraud unit was certified. The investigations were performed by a few members of the attorney general's staff. Only three or four cases were prosecuted by this group before certification. The group's key person has since become director of the Ohio fraud unit. His staff at December 31, 1979, included 10 attorneys and legal interns, 19 investigators, and 7 auditors. On that date, the unit had 38 investigations at various stages of completion. During its first 21 months, the unit's efforts resulted in 18 convictions with recovery settlements and fines and penalties totaling $960,297.

## Illinois

In 1977 administrative audits and investigations of potential fraud by Medicaid providers were conducted by bureaus within the Illinois Department of Public Aid, the single State agency. The investigations resulted primarily in administrative sanctions and recoupment of overpayments. State prosecutors had prosecuted few provider cases. To provide unified and systematic investigation and case presentation for criminal prosecution, the function was transferred to the Department of Law Enforcement. This department established, in April 1978, the Financial Fraud and Forgery Bureau to investigate all alleged criminal conduct regarding welfare assistance programs in Illinois, including providers and recipients. The Illinois fraud unit was established within this bureau in April 1978. As of December 31, 1979, the unit had 2 attorneys, 20 investigators, and 1 accountant/auditor assigned to investigate and prosecute Medicaid provider fraud, and its efforts resulted in five convictions.

## FRAUD UNIT DETERRENT EFFECTS AND OTHER CONTRIBUTIONS

One of the most significant ways in which fraud units affect Medicaid fraud prevention may well be the deterrent their existence creates to dissuade Medicaid providers from attempting fraud. Indications that fraud units create a deterrent to fraud include providers who voluntarily turn themselves in and overall reductions in claims for Medicaid services by certain providers.

Another important impact that State fraud units have had on Medicaid fraud is their contributions to changes in State legislation and Medicaid regulations that have made it easier to identify fraud and provide for more stringent penalties. Also, they have identified weaknesses in the State Medicaid agencies' claims payment systems and made recommendations to change ineffective regulations and to establish regulations when needed.

### Deterrent effects

In debating the funding of State fraud units, the Congress recognized that, in the absence of effective investigative units, individuals engaging in fraudulent practices would be able to continue their activities virtually unchecked. Further, the Congress recognized that the combination of rigorous enforcement and criminal sanctions should serve as a deterrent to such practices.

During our review of the seven State fraud units, we attempted to document and quantify the deterrent effect of fraud units. This proved to be a difficult task for two reasons. First, it is very difficult to assign a dollar amount to deterrent effects. Secondly, such deterrent effects are only evident over long periods of time. Nevertheless, we were able to identify several instances that suggest the existence of deterrent effects.

--In late 1979 the Louisiana unit investigated a pharmacy owner suspected of fraudulently substituting generic drugs for physician-specified brand name products and charging Medicaid for the more expensive brand name items. During the investigation, the unit noted that the suspect owner had reduced the volume of his substitutions and false Medicaid billings substantially after another area pharmacist had been convicted and jailed for similar fraudulent activities. The volume of substitution was reduced from about 60 percent of Medicaid business before the above-mentioned conviction to 15 to 20 percent at the time of the unit's investigation. From 1971-79 the pharmacy owner received about $1.2 million from the Medicaid program--$450,000 of which was believed to have been received fraudulently. In January 1980 he was indicted by a local grand jury for Medicaid fraud.

--The Massachusetts fraud unit's chief investigator attended a pharmaceutical seminar where the pharmacists attending were concerned with the unit's makeup and the types of cases being investigated and prosecuted by the unit. The pharmacists were also concerned about fines and penalties, both civil and criminal; fraud and abuse; and the unit's sources of fraud referrals. In the opinion of a unit supervisor, the unit is having a strong deterrent effect on the pharmacy profession. In addition, the unit has been asked to lecture the Massachusetts Nursing Home Federation on cost report fraud and the American Association of Hospital Administrators on fraud and abuse. Further, the American Health Care Associates, parent affiliate of the State Federation, devoted an entire day to the instruction of "Procedures for Handling Medicaid/Medicare Fraud and Abuse Audits or Investigations."

--The Ohio director believes his unit has a deterrent effect. He cited as examples his discussions with people from dental associations, the Ohio Medical Society, and other groups having an interest in the Medicaid program who have told him that the fraud unit is making the unscrupulous providers more honest since they know they may get caught and prosecuted. One Ohio nursing home case under investigation came to light when the owner of the home called the fraud unit and tried to "make a deal" for some questionable charges to the Medicaid program. This owner claimed the publicity created by another case prompted him to "go straight."

Other contributions

The fraud units also contribute to the overall effectiveness of combating Medicaid fraud by working to change State Medicaid laws and by making recommendations to change Medicaid regulations and policies and improve State Medicaid agency procedures. The changes have made it easier to identify fraud and provide for more stringent penalties.

Five of the units reviewed have had an impact on changing, or attempting to change, State laws. For example, Pennsylvania criminal statutes did not specifically cover fraud by Medicaid providers, but the fraud unit drafted proposed legislation to amend the public welfare code. The proposed legislation, which was signed by the Governor on July 10, 1980, sets Medicaid provider fraud as a felony of the third degree with a maximum penalty of $15,000 and 7 years in prison. In addition, the statute provides that trial courts order any persons convicted to repay the amount of excess benefits or payments plus interest and pay punitive damages not to exceed threefold the amount of excess benefits payments. The legislation also provides for terminating convicted providers from the Medicaid program for 5 years.

The Louisiana fraud unit drafted and proposed an amendment to the Louisiana criminal code in the 1979 session of the State legislature to cover the crime of Medicaid fraud. The elements of this amendment, which was passed in September 1979, essentially track the Federal law in making a single incident of defrauding the Medicaid program a felony, thereby relieving the unit from having to pursue these prosecutions under the State felony theft law.

The Massachusetts fraud unit drafted and assisted in the submission of two remedial laws to deter future fraud and increase the quality of care given patients residing in long-term care facilities. In July 1980 the Governor of Massachusetts signed into law (1) the Medicaid False Claims Act which addresses false statements and has penalties that punish Medicaid fraud and (2) the Patient Abuse and Reporting Act that makes it a crime to abuse, mistreat, or neglect a patient or resident of a hospital, clinic, or long-term care facility.

The Washington fraud unit and its special prosecutor worked on proposals that resulted in the enactment of the Washington State Medicaid Fraud Law, which became effective September 1, 1979. The law not only parallels the Federal law by making Medicaid fraud punishable as felonies, but also sets the maximum civil penalty at three times the excess benefits received.

The New York fraud unit has also made several legislative proposals at the State and Federal levels. For instance, in May 1979 the unit proposed a complete reorganization of home health services into a new title XXI of the Social Security Act to provide better care and more efficient enforcement. In this regard, in June 1980 legislation was introduced in the Senate providing for comprehensive community-based care services for the elderly and disabled.

All of the fraud units we reviewed have made some sort of recommendations to change Medicaid policies and improve agency procedures. Some examples are as follows:

--An Ohio unit investigator with a computer background is currently working with the programing people in the State's data processing center to tailor provider profiles to save staff hours and make the profiles more fraud detection oriented. The investigator is also developing programs to obtain new information from the data base and compare different sets of data to identify potential fraud.

--While investigating a physician during 1979, the Louisiana unit uncovered a deficiency in a State Medicaid agency policy that allowed doctors to bill the program for visits with patients at nursing homes without actually examining the patients. Following a unit recommendation, the agency clarified its policy to require the "laying on of hands" by the doctor in order to legitimately bill the program for a visit.

--The Massachusetts unit has made a number of recommendations to HHS and the State Medicaid agency. It suggested that HHS provide assistance to fraud units in developing comprehensive computer screening programs specifically designed to screen for indications of fraud. Such assistance should include (1) computer consultant expertise, (2) training for State agency personnel, (3) personnel assistance to insure implementation, and (4) providing unit direct access to information maintained by the department of public welfare contractors (computer and auditing).

--The New York unit made recommendations to the State health department designed to accurately establish responsibility for patient care in health care facilities that were incorporated into the State's revised health care code.

## PROPOSED CONTINUED FUNDING FOR FRAUD UNITS

On December 10, 1979, the Senate Committee on Finance favorably reported an extension of the period for funding State Medicaid fraud control units. The report (S. Rept. 96-471) recognized that some States had experienced delays in establishing fraud units and had therefore been unable to fully avail themselves of the increased Federal matching authorized under the law. The Committee approved section 260 of H.R. 934, which extends for 2 years (until Oct. 1, 1982) the period for which 90-percent Federal matching is available for funding State Medicaid fraud control units. 1/ No State may receive such matching for more than 3 years.

On April 23, 1980, the House Committee on Interstate and Foreign Commerce reported H.R. 4000, the Medicare and Medicaid Amendments of 1980. Section 34 of the bill authorizes Federal matching payments to the States for the cost of establishing and operating Medicaid fraud control units at the rate of 90 percent for the first 3 years and 75 percent thereafter. 2/

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1/On June 19, 1980, this provision passed the Senate as an amendment to S. 988, the Health Services Promotion Act of 1979.

2/This provision was included as section 336 of H.R. 7765, the Omnibus Reconciliation Act of 1980, which the House passed on September 4, 1980.

We favor the passage of such legislation as H.R. 4000 because, as discussed in chapter 4, without it many fraud units will probably cease to exist or operate at a reduced level of effectiveness. Also, the establishment of fraud units in additional States is unlikely unless Federal funding is extended beyond September 1980.

However, we believe eligibility to receive such continued Federal funding should be contingent upon effective unit performance. Indicators of effectiveness, such as amount of recoveries, numbers of indictments, and successful convictions, are important to consider but are not the only measures of effectiveness. The fraud units should also be required to meet the operating requirements in the regulations to assure a more effective performance. Also, solving the problems discussed in the following chapters of this report would increase fraud units' ability to meet effective performance standards. We believe that HHS could develop reasonable performance standards for fraud units that would address such effectiveness measures as productivity, case backlogs, adequacy of case referrals made to prosecutors outside the unit, and timeliness and accuracy of meeting HHS reporting requirements.

## CONCLUSIONS

Most State fraud units have not become self-supporting, whereby they identify and collect more fraudulent overpayments than their cost of operations. Those that have been self-supporting may have difficulty remaining so. Additionally, the accuracy of the amounts reported by the units to HHS as potential recoveries is questionable based on the errors we found. Further, some units have not maintained information on the amount of the overpayments identified for recovery that has actually been collected to defray their operating costs.

Nevertheless, the creation of Medicaid fraud units has resulted in increased investigation and prosecution of Medicaid fraud in States that have established units. Also, fraud units, by their very existence, appear to be a deterrent to Medicaid fraud and have contributed to improving the operation of State Medicaid programs. The combined effect of these benefits--while not measurable in terms of dollars, except for recoveries--could outweigh the fraud units' costs of operation. Therefore, we believe that fraud units can be an effective force in combating Medicaid fraud and that their effectiveness should increase as they gain experience and expertise in investigating and prosecuting Medicaid fraud.

However, if some type of continued Federal funding is not provided, it is likely many fraud units will cease to exist or operate at a reduced level of effectiveness. Legislation has been proposed (H.R. 4000) to authorize Federal matching payments to the States for the cost of establishing and operating Medicaid fraud control units at a rate of 90 percent for the first 3 years and 75 percent thereafter. We favor the passage of such legislation, but believe eligibility to receive such continued funding should be contingent upon effective unit performance.

## RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct the HHS Inspector General to:

--Verify, on a sample basis, the accuracy of the statistics included in the State fraud units' quarterly reports on their fraud investigation activities.

--Determine which fraud units do not have adequate procedures for following up on the amount of overpayments actually collected and require them to establish appropriate procedures.

## RECOMMENDATION TO THE CONGRESS

To encourage the continued investigation and prosecution of Medicaid fraud, we recommend that the Congress provide for funding the establishment and operation of State Medicaid fraud control units beyond September 1980. Such legislation should require HHS to annually certify for continued funding only units that have demonstrated effective performance based on reasonable performance standards established by HHS.

## HHS AND FRAUD UNIT COMMENTS AND OUR EVALUATION

HHS and four of the seven State fraud units we reviewed commented on a draft of this report. Because the fraud units' comments essentially addressed the statements in the report relating to their particular unit and not our conclusions and recommendations, we have not included them as appendixes in this report. However, we have incorporated their comments where appropriate in the report.

HHS concurred with our two recommendations. (See app. II.) It plans to review the accuracy of the statistics contained in the units' quarterly reports and the adequacy of the units' procedures for following up on the amount of overpayments actually collected during the onsite recertification visits.

Regarding our recommendation to the Congress, HHS said that, in the recertification process, the regulations require that the Secretary give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities. Thus, HHS said it is required by regulation to comply with our recommendation requiring demonstrated effective performance by fraud units as a prerequisite to recertifying them.

We agree with HHS' first statement but not fully with the second. While the regulations do require the Secretary to give special attention to certain indicators of unit effectiveness in determining if a unit should be recertified, the regulations do not contain performance standards that a unit must meet to be recertified. We have clarified the report by expressing our belief that HHS could develop reasonable performance standards for the fraud units that would address such effectiveness measures as productivity, case backlogs, adequacy of case referrals made to prosecutors outside the unit, and timeliness and accuracy of meeting HHS reporting requirements.

The purpose of our recommendation is to help HHS administer the certification process by developing more objective measures of effectiveness.

## CHAPTER 3

## BETTER REFERRALS FROM AND COOPERATION WITH STATE MEDICAID AGENCIES NEEDED

Success of State Medicaid fraud units depends to a great extent on the adequate development of potential fraud cases referred to them for investigation and the help and support they receive from the State Medicaid agencies in carrying out the investigations. The operations of most of the fraud units we reviewed were adversely affected in these areas to varying degrees.

Potential Medicaid fraud cases referred to the fraud units have generally not been adequately developed in that the information contained in the referrals was insufficient to enable the fraud units to make a meaningful evaluation of fraud prosecution potential. As a result, the fraud units must often perform detection work that should have been done by the State Medicaid agency and also spend effort on cases that do not have good potential for proving fraud. The major problem in this area is that most State Medicaid agencies do not have the ability to identify and develop cases with good fraud potential. We believe this can be attributed, at least in part, to the States' lack of effective Medicaid Management Information Systems (MMISs) and the lack of adequate utilization review staffs who screen and analyze Medicaid payment data.

The effectiveness of fraud unit investigations has also been hampered by problems in the units' dealings with the State Medicaid agencies. As a result, investigations have been slowed, and the possibility that fraudulent providers are not prosecuted increases. These problems indicate the State Medicaid agencies are not in compliance with agreements they and the fraud units reached, which call for the Medicaid agencies to provide the fraud units information and support necessary for case investigations. The agreements are known as memorandums of understanding and are a condition of fraud unit certification.

### MEMORANDUM OF UNDERSTANDING

A fraud unit is required to enter into a memorandum of understanding with the State Medicaid agency to assure that the unit receives the information and support necessary to adequately investigate Medicaid fraud. Specifically, the State Medicaid agency must agree to:

--Refer all cases of suspected provider fraud to the fraud unit.

--Provide promptly at the fraud unit's request (1) access to, and free copies of, any records or information kept by the agency or its contractors, (2) computerized data stored by the agency or its contractors without charge and in the form requested by the unit, and (3) access to any information kept by providers to which the agency is authorized access by section 1902(a)(27) of the Social Security Act (title XIX).

While the requirement to develop such memorandums was met in the States we reviewed, the Medicaid agencies in most States failed to fully comply with them. The consequences of an underutilized MMIS or inadequate Medicaid claims processing system, an inadequate utilization review staff in terms of number and training, and an inadequate level of cooperation from the State Medicaid agency are that fraud units have been hampered in identifying and prosecuting Medicaid fraud.

## STATES DID NOT PROVIDE ADEQUATELY DEVELOPED REFERRALS

Fraud units rely heavily on the State Medicaid agencies for fraud case referrals. To carry out this responsibility, the State Medicaid agency must have a functional management information system and sufficient personnel who are capable of analyzing the information that the system provides. Most of the Medicaid agencies in the States we reviewed generally had not provided adequately developed referrals. This occurred, at least in part, because the Medicaid agencies did not have an effective management information system and/or an adequate Medicaid utilization review staff. Because of the inadequacies of the referrals, the fraud units often had to perform detection work that should have been done by the State Medicaid agencies and spend effort on cases that did not have good fraud potential.

Although most of the fraud case referrals are provided by the State Medicaid agency, fraud units receive referrals from a number of sources, including Federal agencies, other State agencies, the media, Medicaid recipients and providers, providers' employees, and private citizens. The fraud units also identify potential fraud cases based on current case investigations and their own detection efforts.

Fraud detection is not a routine function of the fraud unit. The regulations intended that (1) fraud detection would be done by the State Medicaid agency as a routine part of its provider utilization review and (2) fraud units would focus their activities on the investigation and prosecution of potential fraud. In this regard, the regulations require the State Medicaid agency to refer all cases of suspected provider fraud to the fraud unit. HHS regulations and policies made the fraud units dependent on referrals from the State Medicaid agencies until OIG assumed responsibility for the program and notified the units that detection activities normally associated with law enforcement agencies were proper if they do not duplicate the proper administrative functions of the Medicaid agency.

Officials of most fraud units we reviewed were generally dissatisfied with the number and quality of referrals they received from the State Medicaid agencies. In Louisiana, the fraud unit was in danger of closing because its low caseload did not justify continued operation. Concerning the quality of referrals, officials in most of the fraud units felt they have wasted time on case referrals that

--did not involve Medicaid funds,

--involved invalid allegations,

--were based on information too old to use,

--addressed program abuse but not fraud, or

--did not include enough information to initiate an investigation.

Effect of States' MMISs on referrals to fraud units

The rapid expansion of the Medicaid program since its establishment in 1965 resulted in huge backlogs of claims, payment delays, and provider complaints. Thus, because adequate management controls did not keep pace with this rapid expansion, a need for computer-based claims processing systems became clear. Between 1970 and 1972, HHS developed the MMIS--a mechanized claims processing and information retrieval system model for use by States in developing their own systems. To encourage States to adopt an MMIS, the Congress authorized, in October 1972 with the passage of Public Law 92-603 (section 235), Federal funding for 90 percent of the design, development, and installation costs and 75 percent of the operating

costs for systems approved by HHS, instead of the usual 50-percent cost sharing. Such systems should be capable of

--computerized processing of large volumes of provider claims,

--identification and verification of all eligible recipients and all providers qualified to render services,

--correctly paying providers,

--statistical profiling of health care delivery and utilization patterns, and

--identification of possible instances of fraudulent and abusive practices.

By the end of fiscal year 1979, 27 States and New York City were approved for 75-percent Federal funding. Ten States and the remainder of New York anticipate approval for 75-percent funding during fiscal year 1980. Of the other 16 States/territories with Medicaid programs, 8 were in various stages of MMIS development, and 8 had no active Federal MMIS plan. Of the 27 States with certified fraud units at December 31, 1979, only 17 had an MMIS approved by HHS for 75-percent Federal funding.

A September 1978 GAO report 1/ concluded that the full potential of MMIS was not being realized because of HHS' system approval process and system design criteria. In a June 1979 report, a HCFA MMIS Task Force also concluded that, while MMIS performs important functions in each of the States that have these systems, it is not being used to its full potential. A significant shortcoming of MMIS, as identified by the Task Force, is that fraud, abuse, and waste control mechanisms have not been designed and used as effectively as possible.

Of the seven States we reviewed, only Louisiana, Ohio, Washington, and New York 2/ had received HHS approval for 75-percent Federal funding of their MMIS operating costs. However, as indicated above, HHS approval of a State's MMIS does

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1/"Attainable Benefits of the Medicaid Management Information System Are Not Being Realized" (HRD-78-151, Sept. 26, 1978).

2/Only claims submitted to New York City are processed on an MMIS. Other areas of the State were not covered by an MMIS.

not assure that it can provide the information necessary to adequately develop a fraud case. Without such assurance, potential fraud goes undetected, and in some instances, identified fraud may not be completely developed and therefore not prosecuted.

In Washington, lack of funding resources has precluded the State Medicaid agency from developing special programs for the MMIS that would detect potential fraud. Furthermore, HHS regulations and policies restrict the fraud unit's detection activities in areas, such as computer programing, which are the responsibility of the Medicaid agency. In addition, Washington's MMIS has the capability to retrieve provider profiles 1/ for only the current 15-month period. For prior periods, the data are accessible only by manually searching payment documents filed by payment date. This manual search involves substantial staff resources since thousands of payment documents must be reviewed.

The difficulties and delays in obtaining provider information have caused corresponding delays in investigations and have occasionally prevented cases from being fully investigated. For example, a provider was alleged to have billed Medicaid for services while out of the country. Since the period involved was 23 to 25 months before the fraud unit received the case, the unit could not obtain provider profiles for this period. The prosecutor believed that the billing irregularities which existed in the current 15-month period lacked the significance to demonstrate fraud. The investigator attempted to manually extract provider payment data for the previous period. However, this task was not completed because neither the fraud unit nor the State Medicaid agency believed its staff resources should be used for searching through thousands of payment documents.

A Washington unit supervisor reported to the State Medicaid agency on the inadequacy of the 15-month retention period in March 1978. Two years later, State Medicaid officials were still studying the feasibility of extending the retention period.

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1/Profiles are lists, for a specified period of time, of all services furnished by a provider.

Ohio fraud unit representatives also cited the problem of obtaining adequate information from the State's MMIS. However, the unit has taken a positive step toward resolving this problem. One investigator with a computer background has been working directly with the MMIS staff to design formats for programs which will provide the required information. This investigator estimated that her assistance with computer printout formats has been requested in about 50 percent of the unit's cases. She is now learning about the MMIS so that she can help program the computer to detect potential fraud.

The other States we reviewed--Illinois, 1/ Massachusetts, and Pennsylvania--did not have an HHS-approved MMIS. In Massachusetts, claims were processed at two locations--the State Medicaid agency and a private contractor. The fraud unit requested computerized information monthly. Also, the unit made such requests through the State Medicaid agency due to contractual agreements. While the State Medicaid agency responds to unit requests quickly, the contractor was taking 2 to 3 months to respond to such requests. Accordingly, investigations were delayed for several months. In addition, the contractor did not always provide printouts that gave the minimum data required by the fraud unit. The unit chief believed that these problems would be resolved with MMIS implementation.

Lack of an operational MMIS in Pennsylvania was discussed in an earlier GAO report. 2/ Also, a recent Pennsylvania State Senate report on Medicaid fraud and abuse concluded that the Medicaid claims processing system is virtually an open door to anyone submitting a claim for payment and continues to exist because of the excessive delay by the department of public welfare in implementing an integrated computerized claims processing system. This lack of an operational MMIS has resulted in fraud unit staff performing detection tasks that would be considered the routine work of the State Medicaid agency.

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1/Illinois has contracted for the design and implementation of an MMIS, but at the time of our fieldwork, an MMIS had been only partially implemented.

2/"Pennsylvania Needs An Automated System to Detect Medicaid Fraud and Abuse" (HRD-79-113, Sept. 24, 1979).

## Effect of States' Medicaid utilization review on referrals to fraud units

Each State Medicaid agency has staff responsible for reviewing provider utilization of the Medicaid program. The Medicaid agencies' utilization review groups in most States we reviewed often provided inadequately developed case referrals to the fraud unit. Understaffing of the utilization review function in State agencies and a lack of formal guidance to State agencies from HHS and the fraud units have contributed to the problem.

We noted cases of inadequacies in or inappropriateness of referrals by the State Medicaid agencies' utilization review groups to the fraud units in most States we reviewed. For example, in Louisiana, cases were referred which contained outdated information and invalid allegations. In Illinois, cases were referred which had been previously investigated by other State agencies which had concluded that no fraud existed. In Pennsylvania, cases were referred which (1) did not involve Medicaid funds and (2) were based on telephone calls without any investigative work being done. In Ohio and Washington, cases were referred which were abuse situations rather than potential fraud.

In the spring of 1979, HCFA and OIG jointly surveyed the relationship between the fraud units and the State Medicaid agencies and reviewed the Medicaid agencies' utilization review function. They found that fraud units in 10 of the 23 States they visited believed the Medicaid agency's development of case referrals was inadequate--7 characterized this development as poor and 3 fair. HHS has not provided formal case referral guidelines to State Medicaid agencies. Initially, HCFA considered this task the responsibility of the fraud units. Since transfer of the responsibility for the fraud unit program from HCFA to OIG, limited staff has precluded OIG from developing and disseminating case referral guidelines. Consequently, the task was relegated to the fraud units, which have made little progress. Concerning the Medicaid agencies' utilization review function, the survey team found that, in most States, the lack of adequate staff for this function affected the output of potential fraud case referrals to the fraud units.

Due to the inadequacies in referrals from State Medicaid agencies, the fraud units performed case development and, in

some States, fraud detection tasks that routinely would have been performed by the Medicaid agency's utilization review group. The following examples illustrate this situation.

The Massachusetts fraud unit assigned personnel directly to the State Medicaid agency in an attempt to generate fraud case referrals. Fraud unit and utilization review staffs together reviewed over 2,000 provider files that, according to the utilization review group, contained evidence of abuse, neglect, and overutilization, but not fraud. As a result of that effort, the fraud unit opened 44 potential fraud cases for investigation, several of which resulted in convictions, restitutions, and fines. The fraud unit identified 30 other potential fraud case referrals through its review of State Medicaid agency files. These 74 self-generated cases accounted for 39 percent of the referrals credited to the State Medicaid agency and 23 percent of referrals from all sources from date of certification through January 1980.

The Massachusetts fraud unit believes that a planned increase in the number of staff in the Medicaid agency's utilization review group plus its planned training of the group's staff should result in more and better developed referrals. However, the utilization review group has a large backlog of provider audits to complete before it can devote time to referrals of fraud cases.

The Louisiana fraud unit, which was certified in March 1978, had received only 148 case referrals from all sources through December 1979. Fraud unit officials considered only about two-thirds of those as legitimate cases of potential Medicaid fraud. Because the low caseload did not justify continued operation, the State attorney general considered closing the fraud unit. However, in October 1979 the fraud unit received verbal permission from OIG to start fraud detection efforts as long as it did not duplicate State Medicaid agency efforts. As a result of its detection efforts, the fraud unit initiated cases against 20 pharmacies.

No formal guidelines that explain what constitutes a good referral have been provided State Medicaid agencies. An HHS report on the cooperation between fraud units and Medicaid agencies recommended that the two groups jointly develop guidelines on when a potentially fraudulent case should be referred to the fraud unit, what type of data should be included, and to what extent development should be done by the Medicaid agency. We agree that such guidelines should be developed.

but by OIG in its role of Federal administrator of the Medicaid fraud control unit program in consultation with the fraud units and State Medicaid agencies. One of the fraud units reviewed has begun providing instruction on case development to the State Medicaid agency utilization review group, but such instruction has generally been sporadic and geared toward individual cases.

## COOPERATION BETWEEN FRAUD UNITS AND STATE MEDICAID AGENCIES

As required by law, State fraud units must remain separate and distinct from the "single State agency" that administers the Medicaid program. However, the units depend greatly on State Medicaid agencies for fraud detection and information to assist in Medicaid fraud investigation and prosecution. Because of the units' informational needs and, more basically, because the units and State Medicaid agencies share the common goal of making Medicaid payments in the proper amount to only those who qualify, the two entities should be cooperating fully. This is an important prerequisite to help ensure effective unit operation.

Most of the fraud units we reviewed experienced some problems in dealing with their State Medicaid agency. Some units had more problems than others, and some units have greatly improved their relationships since initial certification.

--The Louisiana fraud unit and the State Medicaid agency have exhibited a lack of mutual interaction and a failure to hold joint meetings to discuss and work out problems. The fraud unit does not have ready access to Medicaid payment data maintained by the Medicaid agency or its fiscal agent. Unit officials believe the Medicaid agency's slow response to information requests has generally delayed its case investigations. The fraud unit has contributed to problems in this relationship by providing no feedback on case status to the Medicaid agency until case closure. Unit officials believe such feedback could be leaked to the provider and consequently jeopardize an investigation. They are concerned with the Medicaid agency's basic philosophy--which is welfare and social services oriented--and believe that, in accordance with this philosophy, the Medicaid agency is reluctant to question provider billings for fear providers will withdraw from the program.

--In Washington, the length of time required for obtaining claim copies from the State Medicaid agency varied from a few days to 3 months, depending on the agency's workload. In one of the fraud unit's investigations, a county prosecutor, impatient with a 3-month wait for the claim copies requested by the unit, subpoenaed them from the State. The State Medicaid agency director told us that, because of limited staff resources, the agency could not respond promptly to the unit's requests and that the agency's routine claims processing responsibility has first priority. He also told us that the memorandum of understanding with the unit requiring prompt reply to all requests is no longer practical because of the agency's limited resources and the increasing demands for information.

--In Massachusetts and Ohio, relationships between the fraud units and the State Medicaid agencies were strained because the State agencies were concerned over the loss of authority and control of Medicaid fraud investigations. There were also personality conflicts and resentment of the publicity given to the fraud unit and the corresponding lack of publicity given to the Medicaid agencies' efforts.

--In Ohio, Louisiana, New York, and Washington, the fraud units provided little feedback to the Medicaid agencies on the status of their investigation of specific cases. This not only created animosity but also prevented the Medicaid agencies from contributing to the investigations. The Ohio fraud unit is illustrative of this problem. Officials in this fraud unit told us they are required to maintain complete confidentiality about a case until the provider is indicted or the case is closed. Also, the fraud unit's reluctance to share case information with the State Medicaid agency increased because an agency employee had allegedly committed Medicaid fraud and was under investigation by the fraud unit. Further, the State Medicaid agency was directed by HHS to audit high-volume providers. The Medicaid agency had earlier sent case referrals to the fraud unit on some of those providers. Because fraud unit officials would not provide information on their investigation of those cases, the Medicaid agency was relegated to either delaying its own investigation or duplicating the fraud unit's efforts.

## CONCLUSIONS

Potential fraud cases referred to State fraud units from State Medicaid agencies have generally not been adequately developed. Many cases are not developed to the point where potential fraud is demonstrated, and many involve abuse rather than fraud. Most States' Medicaid agencies do not have the ability to identify and develop cases with good fraud potential because they lack an effective MMIS and adequate staff to analyze Medicaid payment data.

No criteria have been established by the States or HHS on the extent to which a potential fraud case should be developed before referral to the fraud unit and what types of data and analysis should be included. Although in some States fraud unit personnel have provided some training to State Medicaid agency personnel on techniques to be used to develop fraud cases, this has been left to individual States with no formal guidance or direction from HHS.

Fraud unit investigations have also been hampered by problems in fraud units' dealings with the State Medicaid agencies. Mutual distrust, concern over loss of control of fraud investigations, and personality conflicts contributed to this situation. As a result, investigations have been slowed, and the possibility that fraudulent providers are not prosecuted increases.

## RECOMMENDATION TO THE SECRETARY OF HHS

We recommend that the Secretary direct the HHS Inspector General to develop criteria, in consultation with fraud units and State Medicaid agencies, to guide Medicaid agencies on the extent to which a potential fraud case should be developed before referral to the fraud unit and what types of data and analysis should be included in the referral.

## HHS COMMENTS

HHS concurred with our recommendation. It said that personnel from the State Medicaid agency directors association, State Medicaid fraud control unit directors' association, and OIG staff have developed a model memorandum of understanding between the State Medicaid agency and the fraud unit which will include criteria for referral of potential fraud cases. HHS said this is a priority item to the involved parties, and while

it is realized that complete agreement may not be reached by all the States, it is anticipated that minimum guidelines will be agreed to by nearly all the participants.

We also noted that proposed revisions to the Federal regulations, which HHS hopes to publish as a notice of proposed rulemaking in the near future, would require that the written agreement (memorandum of understanding) entered into by the fraud unit and State Medicaid agency include criteria and formats for referral of cases and procedures for the exchange of information. We believe that, if the revised regulations are adopted and OIG staff review the adequacy of the case referral criteria contained in the agreements, this action will satisfy the intent of our recommendation.

## CHAPTER 4

## PROBLEMS IN HIRING, RETAINING, AND TRAINING FRAUD UNIT PERSONNEL

Effective functioning of State Medicaid fraud control units depends largely on the qualifications and capabilities of their staff. The law provides that fraud units employ auditors, attorneys, investigators, and other necessary personnel to promote the effective and efficient conduct of the units' activities. To achieve this purpose, the unit staff should have a working knowledge of the Medicaid program and an educational background and/or work experience in white-collar crime investigation and prosecution. The fraud units we reviewed have experienced problems in hiring and retaining qualified staff. Factors contributing to this problem include:

--Low State salary schedules for auditors, investigators, and attorneys.

--State budget constraints affecting available funds and personnel ceilings.

--Uncertainty of Federal funding after September 1980.

As a result, the fraud units have had trouble attracting qualified people, and some have experienced high staff turnover. The fraud units' effectiveness has also suffered because many of their staff have not received proper supervision, and in some cases, the training provided to the staff has been inadequate.

Fraud units generally require a full year to become operationally effective. The New York unit achieved its anticipated operational level during the first year of funding because it was the successor agency of the Office of the Special Prosecutor for Nursing Homes, Health and Social Services established in 1975 under a New York State Executive Law. However, the other units suffered "growing pains" in establishing permanent work locations and in finding potential employees with even a limited knowledge of the Medicaid program or a fraud investigation background. The scarcity of people with experience in white-collar or financial-crime investigations or in large-scale fraud-oriented audits of institutions is a countrywide problem. Therefore, people with this type of experience are difficult to find, let alone hire at the low salaries offered in many States.

## HIRING AND RETAINING FRAUD UNIT STAFF

Though the fraud units receive 90-percent Federal funding, all personnel actions must be taken in accordance with State guidelines. The States determine such factors as salary schedules, personnel levels, and whether to continue funding the fraud unit's operations should Federal support cease. The States' policies on these factors have contributed to the fraud units' problems in hiring and retaining staff.

### Low State salary schedules

Low State salaries affected hiring and staff retention to some degree in all of the fraud units we reviewed. Officials in some units identified this factor as a major difficulty. The following examples demonstrate this problem.

The salary ranges in Pennsylvania may be adequate for inexperienced new hires but, in our opinion, are not adequate to hire or retain experienced staff. The Pennsylvania fraud unit has a central office in Harrisburg and a branch office in Philadelphia. Staffs at both locations are responsible to the unit director. To assure prosecutor availability in the Philadelphia branch office, the fraud unit entered into a contractual agreement with the Philadelphia district attorney. The contract covers calendar year 1980 and includes a $172,757 budget for the services of an assistant district attorney and supporting staff. Under the contract, the assistant district attorney serves as acting regional director of the Philadelphia branch office and receives a higher salary than the unit director does. If restricted to offering State salaries, the fraud unit could not have obtained the services provided by the assistant district attorney and his staff.

In addition, the unit director has delayed hiring a much needed, experienced audit supervisor. She does not believe the available salary level will attract such an employee. Low salaries have also significantly affected staff turnover. Over the 20-month period ended December 31, 1979, the fraud unit lost 13 staff members to other organizations, 8 because of low salaries.

The lack of competitive salaries also resulted in staff retention problems for the New York fraud unit. Low salaries contributed to a high turnover rate for auditors of 21 percent in 1978 and 31 percent in 1979.

In Illinois entry level salaries under the State's merit employment system are not sufficient to attract staff experienced in white-collar crime investigations or prosecutions and Medicaid operations. Consequently, the fraud unit encountered difficulty in hiring experienced staff at the entry level. Only the unit director and one upper level investigator have substantial prior experience in white-collar crime investigations and Medicaid operations.

In the Washington fraud unit, after 21 months from date of certification, the staff's average tenure was only 7 months for an auditor and 12 months for an investigator. Continual staff turnover has delayed and disrupted some cases. For example, one case was assigned to three different investigators during 1 year, resulting in slower than normal progress.

In addition, lack of competitive salaries in Washington has impeded the hiring and retaining of experienced auditors. The fraud unit hired two auditors with virtually no field experience and lost at least one experienced auditor who accepted a job with higher pay and greater opportunity for advancement. Due to lack of an operational audit staff, the unit had to ask the State Medicaid agency's utilization review group to do its field audits. The review group had to schedule the audits into its work plans, which caused fraud unit delays in the investigation of several cases. For example:

--In February 1978, the fraud unit requested the Medicaid agency's utilization review group to audit a pharmacy suspected of billing irregularities. Over 11 months later, the review group notified the fraud unit that the case involved potential fraud, though the audit was still not completed. The review group found 30 instances of potential fraud occurring between 1976 and 1978 and told the fraud unit that the audit results would be available in February 1980. The unit was concerned that the 3-year statute of limitations would elapse before it could fully investigate the case. The statute had already elapsed for two instances of potential fraud that occurred in 1976. Lack of an operational audit section within the fraud unit not only delayed case investigation for 2 years, but also decreased the chance for a thorough investigation because of the statute of limitations.

--In another case, the fraud unit requested a utilization review audit in October 1977. A draft audit report was not made available to the unit until December 1979. Again, lack of an operational audit staff within the fraud unit delayed case investigation.

The Ohio fraud unit encountered difficulty in hiring an audit supervisor with adequate experience in white-collar crime investigations and knowledge of the Medicaid program because of the available salary level. The unit director told us that he would have contracted to fill the position, but the State would not permit the use of contracts on a routine basis to hire staff. In contrast, an OIG official told us that he would encourage fraud units to hire by contract as often as possible when State salaries are not high enough to attract experienced staff.

Ohio fraud unit officials are also concerned with the effect of limited position classifications on staff salaries. Because there are so few State-approved classifications for the investigators, there is a corresponding lack of opportunity for advancement and salary increases. The unit lost its most experienced investigator due to lack of advancement opportunity.

State budget constraints

State budget constraints have also affected hiring and staff retention in some fraud units. Three fraud units we reviewed will not be able to maintain what they consider needed staff levels due to State budget cutbacks or lack of State budget increases.

The Pennsylvania fraud unit had 39 authorized professional staff positions, 32 of which were filled as of December 31, 1979. In October 1979 the unit director requested funding approval from OIG for 25 additional positions, professional and administrative, including 13 to establish a Pittsburgh branch office and 6 each for the Harrisburg and Philadelphia offices. The director expected to hire the unit's first audit supervisor to fill one of those positions. Although OIG granted funding approval of the 25 positions, the unit did not seek such funding due to State budget restrictions. The Governor did not approve an increase for new positions in the unit's 1980-81 budget. The unit director had justified the additional positions based on a considerable caseload increase and expected

further increases. She stated in a memorandum to the State attorney general that her current staff is inadequate to do an effective job.

When certified in May 1978, the New York fraud unit had 489 professional staff. As of December 1979, the unit had lost 58 staff members due to a cut in staff positions by the New York State Bureau of the Budget. In addition, as of November 1979, 30 authorized positions were vacant. Fraud unit officials believe that the positions will remain vacant because the State will not appropriate the funds necessary to fill the vacancies.

In December 1979, the Illinois fraud unit staff consisted of 24 professionals, excluding the assistant attorney general, who is not on the unit payroll. The unit requested an increase in total staff positions to 41 for the fiscal year 1981 budget. However, the State's Bureau of the Budget reduced the increase to 38 positions. 1/ This increase would provide eight additional professional staff primarily for the investigative functions and six additional administrative staff.

Uncertainty of future funding for fraud units

Public Law 95-142 provided for 90-percent Federal funding of certified units for a maximum of 3 years ending September 30, 1980. As discussed in chapter 2, legislation recently introduced in the House would give each unit 90-percent Federal funding for a maximum of 3 years and 75-percent funding thereafter. The lack of a provision for continued Federal funding has affected the units' hiring and staff retention.

The question of future funding and, in effect, continued existence was a major concern of the fraud units we reviewed. Some unit directors have been hesitant to hire staff to whom they cannot assure a position after September 1980. In addition, potential staff have accepted employment elsewhere to avoid the inconvenience of changing jobs later.

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1/According to the unit director, the unit's staffing plan as of August 1980 had been further reduced to 32 positions because of budget restrictions.

Some unit officials believe that a reduction in the level of Federal funding will cause a corresponding decrease in unit staff and/or the functions they perform. They also believe that, if Federal funding stops, State funding will stop, and unit operations will be discontinued. One fraud unit chief predicted that this will result in some Medicaid providers "dancing in the streets" since it will be easier for them to violate the Medicaid system without fear of investigation and/or prosecution.

Federal funding would stop only under section 17 of Public Law 95-142. According to HCFA, fraud units could become a part of the State Medicaid agency and qualify for Federal matching at the 50-percent administrative rate established in section 1903(a)(7) of the Social Security Act. The unit could also continue under contract with the State Medicaid agency and receive 50-percent matching funds.

The States should assure their fraud units do not discontinue operations if the Federal funding level drops so that they can continue to benefit from reduced Medicaid expenditures. The States now receive a proportion of the fraud unit recoveries equal to the percentage of State Medicaid program funds they provide, which ranges from 22 to 50 percent. In addition, the existence of a fraud unit regardless of funding source discourages Medicaid fraud and thus contributes to the integrity of the State's Medicaid program. Consequently, the States would benefit from continuing to fund the fraud units whether or not Federal funding at the current level continues.

The National Association of State Medicaid Fraud Control Unit Directors, which consists of the designated heads of units, supports the proposed legislation, which would provide 90-percent Federal funding for the first 3 years and 75-percent funding thereafter. The association's president told us that, if the Federal funding level drops to 50 percent, the smaller States will have difficulty in maintaining units. He added that unit officials are also concerned that, although legislation to continue Federal incentive funding may become effective by October 1980, it may not be enacted in time to allow for State budget processes to provide matching State funds.

## STAFF TRAINING AND SUPERVISION

The limited availability of staff experienced in white-collar crime investigation and prosecution made adequate training and supervision by the fraud units a necessity. Most fraud

units encountered staff training and supervision problems during their first year of operation. These functions continue to be problems in some of the units. Lack of adequate staff training and/or supervision hinder unit effectiveness.

Training

HHS has recognized the need to assist the fraud units in training their professional staff. To date, HHS, New Jersey, California, and Ohio have cosponsored three week-long national training conferences. These conferences have provided a mixture of training in white-collar crime investigation and Medicaid operations to about 450 members of the fraud units. The success of the training conferences was limited in that many fraud unit staff were not able to attend, and the training provided did not fulfill the needs of all who attended. For example, some States, such as Ohio and Louisiana, limit the number of employees that can travel out-of-State for training. Consequently, unless the training conference is held in that State, only a limited number of fraud unit staff can attend. In addition, Washington fraud unit staff members told us that the HHS-sponsored seminars they attended did not provide enough technically oriented training.

Because the fraud units generally hired staff inexperienced and/or untrained in Medicaid fraud investigation and because HHS' training conferences did not provide all needed training to all unit staff, the fraud units relied heavily on on-the-job training. This training was not adequate.

The New York fraud unit chief auditor acknowledged that the audit staff training program is poorly managed. She considers the lack of a training "model" as the overriding problem.

The Louisiana fraud unit relies heavily on on-the-job training for its investigators. Unit staff training has been limited by lack of Medicaid fraud investigation courses and by the limited number of slots available for HHS-sponsored training conferences. The chief investigator told us that the fraud unit might have been more effective had HHS provided more assistance in staff training.

In Illinois, the Department of Law Enforcement, which includes the Medicaid fraud unit, chose to develop Medicaid fraud investigation expertise internally. However, aside

from limited initial training, this agency has neither provided continuing internal training nor sent staff investigators to external training, such as Medicaid provider fraud courses, conferences, or seminars. However, three unit supervisors had attended external training programs. Department of Law Enforcement and fraud unit officials said that investigators are given primarily on-the-job training. While the unit director said the only restriction on staff training was limited availability of courses for investigators and seating limits for seminars, other Department of Law Enforcement officials told us that training is one of the first areas affected by budget limitations. The lack of a Medicaid fraud training program has restricted investigator training. Only non-Medicaid financial crime refresher courses have been provided.

OIG has recognized the need for increased and more effective training. It plans to sponsor a hospital investigative/audit training course to be presented to other fraud units by the New York fraud unit throughout the remainder of fiscal year 1980. It also has identified possible topics for 2-day training sessions that are more technically oriented as opposed to broad coverage training conferences. In addition, OIG is planning to let a contract to develop and implement an intensive training program to focus on the Medicare principles of reimbursement.

OIG officials also told us that some State fraud units have developed expertise in various areas of Medicaid provider fraud investigation. For example, the New York fraud unit has an excellent audit/investigative program for hospitals and pharmacies, the California and New Jersey fraud units have a good investigative program for laboratories and pharmacies, and the Ohio fraud unit is developing an extensive investigative program for nursing homes. The officials believe that sharing such expertise through cross-training among the fraud units would be highly desirable and is encouraged.

We believe that another effective way to use the expertise that various fraud units have developed would be for OIG to develop a training manual incorporating the most effective techniques and methods for dealing with Medicaid provider fraud based on the experience gained by the fraud units.

Supervision

In some States we reviewed, fraud unit effectiveness was hampered by a lack of adequate supervisory staff. The cause

of supervision problems was twofold--either the fraud unit had no staff supervisor or the supervisors it had did not adequately perform.

With assistance from other States, the effect of supervision problems in some fraud units may be somewhat offset. For example, the New York fraud unit temporarily assigns experienced staff to other States' fraud units to help provide training. In addition, some fraud units have lost experienced staff to other States' fraud units. Staff from the New York unit joined fraud units in Ohio and Pennsylvania. Also, one of the Pennsylvania unit's experienced investigators joined the New Jersey fraud unit.

The Washington fraud unit audit section did not become operational until January 1980 because of difficulties in hiring a supervisory auditor. Consequently, the unit had to request the State Medicaid agency's utilization review group to perform all needed field audits. The review group had to schedule the audits into its work plans; as a result, the audits were not completed quickly and the fraud unit's case investigations were delayed.

The Washington fraud unit also experienced problems due to lack of adequate investigator supervision. For example, an investigator who worked in the unit for 6 months met the State's minimum qualifications for the position, but was unable to adequately investigate cases. According to the investigative supervisor, the individual's experience was insufficient in white-collar crime. In checking three of this investigator's cases, we found that two had been closed before they had been thoroughly investigated. In both cases, the supervisor agreed that the investigation had not been properly completed before case closure. He said that each case would be reopened and, in the future, inexperienced staff would be more closely supervised.

Since initial certification through March 1980, the Pennsylvania fraud unit had not hired an audit supervisor. The audit staff were inexperienced when hired and received little supervision. The unit director considers the need for an experienced audit supervisor as crucial. However, she told us that, because the Governor did not approve a budget increase to cover any new positions, it may be some time before an audit supervisor can be hired.

## CONCLUSIONS

Fraud unit effectiveness has been hampered by a lack of qualified staff. Several factors beyond the unit's control have contributed to this deficiency. The overriding factor is the limited number of people available for hire who have experience or prior training in white-collar investigation and a working knowledge of the Medicaid program. Adding to the difficulty in hiring and retaining qualified staff are low State salaries, State budget constraints, and the uncertainty of continued Federal funding. Some of the fraud units have also failed to provide their staff adequate training and supervision.

OIG has little control over these factors, although it could provide additional assistance in fraud unit staff training. Recent OIG efforts to make fraud unit training more technically oriented and more individualized should improve the training of inexperienced fraud unit staff. However, OIG could further assist State fraud units by developing a training manual.

## RECOMMENDATION TO THE SECRETARY OF HHS

To help the States' fraud units develop and provide training to unit staff to investigate and prosecute Medicaid fraud, we recommend that the Secretary direct the HHS Inspector General to develop a fraud unit training manual incorporating the most effective techniques and methods of dealing with Medicaid provider fraud based on the experience gained by the fraud units.

## HHS COMMENTS

HHS concurred with our recommendation. It said that various training seminars have been conducted at which literature, based on the experience of effective fraud units, has been disseminated. This type of literature will ultimately become part of a training manual which will be developed as additional staff are added to the OIG division administering the program.

# CHAPTER 5

## PROBLEMS IN ASSURING STATEWIDE PROSECUTION CAPABILITY

Public Law 95-142 and the implementing regulations require that State fraud units meet several requirements to be certified. Most notable of these are the requirements that the units have the capability to investigate potential Medicaid fraud and to prosecute cases on a statewide basis or have assured access to such prosecutive ability.

Two State fraud units we reviewed did not implement the formal procedures HHS had approved to assure prosecution of suspected cases of Medicaid fraud on a statewide basis. These units are in States where the State attorney general does not have statewide prosecution authority and formal procedures to assure referral of cases to local prosecutors are required. Another fraud unit did not initially provide for effective coordination between the unit and the attorney general's office for the prosecution of Medicaid fraud.

The failure to assure statewide prosecution under the HHS-approved procedures in the two States was mainly a technical violation since there has been no delay in prosecuting any cases. In the other State, the prosecution of cases was delayed. Even in the two States that have not as yet experienced delays or problems with specific cases, the possibility of future problems exists.

## CERTIFICATION REQUIREMENTS

Public Law 95-142 and the implementing regulations place a number of requirements on State Medicaid fraud control units as conditions for their participation in the program. Since the major purpose of the unit is to investigate and prosecute violation of State laws relating to fraud in the Medicaid program, the unit must be contained within or closely associated with the appropriate prosecuting authority or authorities within the State. There are three alternative locations for the fraud units as provided in 42 CFR 455.300 (d):

> "(1) The unit is located in the office of the State attorney general or another department of State government which has statewide authority to prosecute individuals for violations of criminal

laws with respect to fraud in the provision or administration of medical assistance under a State plan implementing title XIX of the Act; or

"(2) If there is no State agency with statewide authority and capability for criminal fraud prosecutions, the unit has established formal procedures which assure that the unit refers suspected cases of criminal fraud in the State medicaid program to the appropriate State prosecuting authority or authorities, and provides assistance and coordination to such authority or authorities in the prosecution of such cases; or

"(3) The unit has a formal working relationship with the office of the State attorney general and has formal procedures for referring to the attorney general suspected criminal violations occurring in the State medicaid program and for effective coordination of the activities of both entities relating to the detection, investigation and prosecution of those violations. Under this requirement, the office of the State attorney general must agree to assume responsibility for prosecuting alleged criminal violations referred to it by the unit. However, if the attorney general finds that another prosecuting authority has the demonstrated capacity, experience and willingness to prosecute an alleged violation, he may refer a case to that prosecuting authority, as long as his office maintains oversight responsibility for the prosecution and for coordination between the unit and the prosecuting authority."

The regulations require the fraud unit to submit with its application for certification a copy of whatever documents set forth these formal procedures under alternatives (2) and (3) and that these procedures be approved by HHS.

In all cases, the unit must remain separate and distinct from the "single State agency" that administers the Medicaid program. This has been interpreted by HHS as not prohibiting the unit from being placed under an "umbrella agency" which supervises a number of entities, including the "single State agency." The unit, however, must maintain a totally separate budget and staff and must have no direct line responsibility to the Medicaid agency.

To receive payments under the program, the fraud unit must submit an application, which has been approved and signed by the State Governor, to OIG. The period of approval is for 1 year, with a recertification required for each additional year of participation.

## NEED TO CLARIFY TYPE OF FORMAL PROCEDURES TO BE ESTABLISHED

Public Law 95-142 provides three alternative locations for fraud units. The first provides for a central investigation/prosecution unit to be located in the State attorney general's office or other department of government which has statewide criminal fraud prosecution authority. Alternative (2) provides for a situation in which there is no statewide prosecuting authority. Alternative (3) responds to the complaints of States that were reluctant to reorganize their governmental structure to the extent necessary to move an investigative unit into the attorney general's office by providing that the unit have a formal working relationship with the State attorney general. One of the problems with these last two alternatives that has arisen is the type of "formal procedures" and "formal working relationships" that have to be established to assure statewide prosecution. This has not been clearly defined by HHS.

In our prior report referred to on page 27, we concluded that the Pennsylvania fraud unit did not implement the formal procedures HHS had approved to assure statewide prosecution of fraud cases. The fraud unit's procedures stated that the unit was going to notify local prosecutors throughout Pennsylvania that it would be referring cases of suspected Medicaid fraud to them for prosecution. However, this letter was not sent and the unit had an agreement with only 1 of 67 local prosecutors. We concluded that this one agreement could not alone meet the requirement for formal procedures because it only covered a part of Pennsylvania's Medicaid population and the regulations specifically require the fraud unit's program to be statewide.

HHS comments on this report stated that formal procedures with local prosecutors for the referral of cases are necessary. However, HHS indicated one practical problem to be overcome in a State such as Pennsylvania, which has many independent local prosecutors, is to obtain specific formal agreements with each of them, as there is no single entity with the authority to represent all of the local prosecutors' offices.

## EXTENT OF PROBLEMS IN STATEWIDE PROSECUTION

As of December 31, 1979, there were active Medicaid fraud units in 27 States; 17 were certified in States where the State attorney general has statewide prosecuting authority and were located in the attorney general's office (alternative 1). Nine units were certified in States where there was no statewide authority and capability for criminal fraud prosecutions (alternative 2). One fraud unit was certified in a State where the attorney general had statewide prosecuting authority, but the unit was not located in the attorney general's office (alternative 3).

Three of the fraud units included in our review were certified under alternative (2), and one unit was certified under alternative (3). A discussion of three of these States and the problems we noted follows: 1/

### Pennsylvania

HHS certified Pennsylvania's fraud unit for 90-percent Federal funding in August 1978, thereby approving the formal procedures the unit proposed to establish which included a letter to be sent to local prosecutors throughout Pennsylvania after certification. Although the proposal letter did not discuss the specific procedures the unit would use to refer suspected fraud cases or assist and cooperate with local prosecutors, HHS approved the proposal as meeting the requirements of the law and regulations. However, the letter was not sent to local prosecutors, although certification had been granted. Furthermore, the unit was recertified in March 1979, although no action had been taken on the letter by that time.

A letter was sent to 66 of the 67 local prosecutors on June 11, 1979, about 3 months after HHS recertified the unit. The letter stated that the unit was ready to help and get help from the local prosecutors in investigating Medicaid

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1/Another fraud unit certified under alternative (2), which was discussed in the draft of this report, was deleted because, under HHS' interpretation of the statute, the procedures as approved by HHS meet the minimum requirements of the law although there were no formal arrangements in place between the fraud unit and local prosecutors.

fraud and abuse and also contained information on how fraud unit attorneys would work with local prosecutors. The unit director said that, in her opinion, the letters and related information sent to the local prosecutors satisfied the requirement that formal procedures be established to assure referral. She added that she had received numerous telephone calls and letters from the local prosecutors indicating their full cooperation and assistance. We noted that 10 written replies had been received indicating full cooperation and assistance on fraud cases. The director said that there have been no cases where the local prosecutor has refused to cooperate or provide assistance, and if such a case would arise, the State attorney general has the power to supersede the local prosecutor for cause and upon court order. In addition, the attorney general can prosecute those cases resulting from the multicounty grand jury. We found no evidence that fraud cases were delayed or lost due to lack of cooperation by local prosecutors.

Washington

The State attorney general does not have authority for statewide criminal prosecution. Criminal prosecution for violating State law is the responsibility of each of the State's 39 county prosecutors. Accordingly, the fraud unit applied for certification under alternative (2) and was certified by HHS retroactive to April 1978. In justifying the certification, HHS stated that, through the cooperation of the Washington Association of Prosecuting Attorneys, an association of county prosecutors, the State had developed the capability for statewide prosecution. The State reportedly entered into a contract with the association for two special Medicaid fraud prosecutors and, in turn, each of the 39 county prosecutors had signed agreements delegating appropriate prosecution authority to the association. HHS concluded that these 39 agreements constituted the formal working relationship in each county to assure the statewide prosecution of Medicaid fraud.

However, we noted that only 7 of the 39 counties had entered into the agreements described in the certification justification. One of the association's Medicaid special prosecutors told us that agreements had not been sought with all 39 counties. Contrary to HHS' justification, the association would not seek an agreement with a county until the special prosecutor decided a case may warrant prosecuting in

that particular county. As of December 1979, only one county prosecutor had refused to delegate his prosecuting authority. He refused because he preferred to prosecute Medicaid fraud cases himself. However, neither the association nor the fraud unit had established formal agreements with this county or with the other 31 counties that had not delegated prosecution authority.

Fraud unit officials acknowledged that their relationships with county prosecutors technically may not comply with the regulations. However, while the absence of formal agreements had not adversely affected prosecutions, the officials acknowledged that this potential existed. Furthermore, the seven counties that had delegated prosecuting authority to the association accounted for most of the State's population.

Fraud unit officials told us that, when the unit was recertified in April 1979, HHS did not question the absence of formal agreements with each county. Unit officials said that they were evaluating their relationship with the association's special prosecutors, but were unsure how to change this arrangement to comply with the regulations. We believe that problems like this occur mainly because HHS has not issued written guidelines on what type of case referral procedures are required for States, like Washington, where there is no provision for statewide criminal fraud prosecution.

Illinois

The Illinois fraud unit is not located in the State attorney general's office, but within the State's Department of Law Enforcement. Accordingly, it was certified in May 1979 under alternative (3). An agreement between the Governor and attorney general established the attorney general's role to include

--reviewing referred cases for potential prosecution or civil recovery and

--undertaking, where deemed suitable, criminal prosecutions or civil actions to obtain and collect judgments for moneys due to the State.

Although the agreement did not qualify the attorney general's powers to undertake civil actions, criminal prosecutions were qualified as follows:

"To the extent the Attorney General's powers to independently undertake criminal prosecutions are limited by law, he will seek to obtain the cooperation of the appropriate county State's attorneys to undertake these prosecutions either independently or in conjunction with the Attorney General."

The fraud unit director believes that the agreement between the Governor and attorney general meets all HHS requirements for alternative (3) status. His opinion is based on a 1978 Illinois Supreme Court decision, which concluded that the attorney general had common law authority for criminal prosecutions. Moreover, the court decision ruled that, since the local prosecutor did not object, the Illinois attorney general was acting within the scope of his statutory duties in making presentations before the county grand jury.

When HHS certified the fraud unit in May 1979, it certified the unit for the first year retroactively to June 1978. During its first year of operation, the unit did not have an appointed representative of the attorney general's office to assist it in prosecutions. During this time, cases were referred to local or Federal prosecutors on a case-by-case basis. An assistant attorney general was appointed as chief prosecutor for the fraud unit in July 1979. Thus, for the first year of operation, the agreement between the Governor and attorney general did not result in effective coordination of activities between the unit and the attorney general's office with respect to prosecuting suspected criminal violations relating to the Medicaid program.

Currently, the assistant attorney general plans to prosecute the criminal cases in Cook County (Chicago) under an agreement with the local prosecutors and in all other counties under case-by-case arrangements with local prosecutors. Some cases may also be referred to Federal prosecutors if this is viewed as advantageous.

The year delay in appointing a prosecutor for the fraud unit resulted in prosecution delays for six cases because the local prosecutors deferred the cases or the attorney general's office requested they be delayed until such appointment. Also, the lack of early prosecutor involvement in the unit's investigations caused prosecution delays.

## CONCLUSIONS

The intent of the Congress, when passing Public Law 95-142, was to assure that Medicaid fraud cases throughout a State would be prosecuted. The provisions of the law and the implementing regulations set up three alternatives under which State fraud units could operate to assure that the units had the ability to prosecute cases on a statewide basis.

Two State fraud units did not implement the formal procedures HHS had approved to assure prosecution of suspected cases of Medicaid fraud on a statewide basis. These units are in States where the State attorney general does not have statewide prosecuting authority, and formal procedures to assure referral of cases to local prosecutors are required. Another fraud unit did not initially provide for effective coordination between the unit and the attorney general's office for the prosecution of Medicaid fraud.

The failure to assure statewide prosecution under the HHS-approved procedures in the two States was mainly a technical violation since there has been no delay in prosecuting any specific cases. In the other State, the prosecution of cases was delayed. Even in the two States that have not experienced delays or problems with specific cases, the possibility of future problems exists.

The best way to assure prosecution of Medicaid fraud cases developed by the units would be for OIG to certify fraud units only in States where the attorney general has statewide prosecuting authority. Since the authority that attorneys general have is dictated by State law and circumstances in each State, often including political considerations, OIG has no authority to change these situations. Therefore, it is important that fraud units, in States where the attorney general does not have statewide authority, obtain the proper assurances from local prosecutors to assure such statewide prosecution.

## RECOMMENDATIONS TO THE SECRETARY OF HHS

We recommend that the Secretary direct the HHS Inspector General to:

--Reassess the the adequacy of the arrangements now in effect in States where the attorney general's office does not have statewide criminal fraud prosecution authority, or if it does, the unit is located outside that office to assure that prosecution can be carried out as needed statewide.

--Decertify those State fraud units that do not meet the statewide prosecution requirement of the law and regulations.

--Issue guidelines on essential elements that should be included in a fraud unit's formal procedures with local prosecutors or working relationships with the State attorney general to assure statewide prosecution of fraud cases.

## HHS COMMENTS AND OUR EVALUATION

HHS generally concurred with our recommendations. However, HHS said it disagreed with our interpretation of the applicable regulations. The regulations require that, if there is no State agency with statewide prosecution authority, that unit must establish "formal procedures which assure that the unit refers suspected cases of criminal fraud in the Medicaid program to the appropriate State prosecuting authority or authorities." Thus, HHS contends there are presently no requirements in the statute or regulations for an agreement with local prosecutors, but merely formal procedures approved by HHS.

As we pointed out in the report, HHS has not clearly defined the type of formal procedures that fraud units are required to establish to assure statewide prosecution. Therefore, the question of strict compliance is difficult to address. Although we agree that the law and regulations do not specifically state that agreements with local prosecutors are required, we believe such agreements could better assure direct access to prosecutional power. and we have clarified our position in the report.

HHS agreed with our recommendation that guidelines be issued on the essential elements that should be included in fraud units' formal procedures with local prosecutors. HHS said its proposed revisions to the regulations would require, if no State agency has statewide prosecution authority, that

the fraud unit enter into formal agreements with local prosecutors having jurisdiction over a substantial part of the State's Medicaid provider community--not all local prosecutors. The agreements must provide that

--the unit will refer each suspected case of fraud in providing medical assistance under the State Medicaid plan to an appropriate prosecutor,

--the unit will assist the prosecutor in prosecuting each case referred,

--each prosecutor will prosecute each case referred unless he or she determines that prosecution is not warranted because of insufficient evidence of guilt, and

--each prosecutor will appoint one or more of the unit's attorneys to try each case referred by the unit or will give such cases the highest priority for prosecution.

We believe that, if the revised regulations are adopted, they will satisfy the intent of our recommendation.

APPENDIX I

## EXPENDITURES AND POTENTIAL RECOVERIES OF STATE MEDICAID FRAUD CONTROL UNITS SINCE THEIR EFFECTIVE CERTIFICATION DATES THROUGH DECEMBER 31, 1979 (note a)

| State fraud unit | Expenditures | Potential recoveries (note b) |
|---|---|---|
| Alabama | $ 528,164 | $ 1,721,163 |
| Arkansas | 253,769 | 112,609 |
| California | 2,792,070 | 359,054 |
| Colorado | 711,827 | 1,163,913 |
| Connecticut | 461,466 | 246,446 |
| Delaware | 19,252 | - |
| Hawaii | 313,654 | 39,190 |
| Idaho | 157,006 | 10,545 |
| Illinois | 649,394 | c/117,293 |
| Louisiana | 414,686 | c/114,296 |
| Maine | 81,663 | 6,000 |
| Maryland | 435,378 | 10,107 |
| Massachusetts | 1,948,101 | c/2,838,309 |
| Michigan | 1,402,651 | 650,520 |
| Nebraska | 180,147 | 25,162 |
| New Jersey | 2,027,400 | 435,777 |
| New Mexico | 507,079 | 66,240 |
| New York | 17,331,877 | c/6,747,021 |
| North Carolina | 212,152 | 142,451 |
| Ohio | 1,025,537 | c/960,297 |
| Pennsylvania | 1,787,699 | c/152,917 |
| Rhode Island | 292,609 | 483,007 |
| Texas | 398,767 | 27,927 |
| Vermont | 175,686 | 43,003 |
| Washington | 788,586 | c/126,420 |
| West Virginia | 14,008 | 43,000 |
| Wisconsin | 1,097,927 | 2,539,018 |
| Total | $36,008,555 | $19,181,685 |

a/Between January 1 and April 30, 1980, OIG certified fraud units in Kentucky, Montana, Utah, and the District of Columbia.

b/Includes fines and penalties, restitutions ordered, and overpayments established. The figures do not include potential recoveries before July 1, 1978. Since most of the units were not in operation before that time, these recoveries would be insignificant.

c/Potential recoveries in the States included in our review were audited and computed by us. The other States' potential recoveries are based on unaudited reports to OIG.

APPENDIX II

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF THE SECRETARY
WASHINGTON, D.C. 20201

Office of Inspector General

AUG -8 1990

Mr. Gregory J. Ahart
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Ahart:

The Secretary asked that I respond to your request for our comments on your draft report entitled, "Are State Medicaid Fraud Control Units Effective? Should Federal Funding Continue?" The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard B. Lowe III
Inspector General (Designate)

Enclosure

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE'S DRAFT REPORT ENTITLED, "ARE STATE MEDICAID FRAUD CONTROL UNITS EFFECTIVE? SHOULD FEDERAL FUNDING CONTINUE?"

General

After reviewing seven State Medicaid Fraud Control Units GAO concludes that Fraud Units can be effective, and recommends that Congress continue funding units beyond September 30, 1980, and require that units demonstrate effective performance to receive funding. In the recertification process, the regulations require that the Secretary will give special attention to whether the unit has used its resources effectively in investigating cases of possible fraud, in preparing cases for prosecution, and in prosecuting cases or cooperating with the prosecuting authorities. Thus, the Department is required by regulation to comply with GAO recommendation requiring demonstrated effective performance on the part of the fraud units as a prerequisite to recertifying the units.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to verify, on a sample basis, the accuracy of the statistics included in the States fraud units' quarterly reports on their fraud investigation activities.

Departmental Comment

We concur. It is part of our plan to review the units' quarterly reports during the on-site recertification visits. Any discrepancy noted is reviewed in detail.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to determine which fraud units do not have adequate procedures for following-up on the amount of overpayments actually collected and require them to establish appropriate procedures.

Departmental Comment

We concur. See above (on-site review).

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to develop criteria, in consultation with fraud units and State Medicaid agencies, to guide Medicaid agencies on the degree to which a potential fraud case should be developed before referral to the fraud unit and the type of data and analysis to include.

Departmental Comment

We concur. Personnel from the State Medicaid Agency Directors Association, State Medicaid Fraud Control Unit Directors Association and OIG staff have developed a model memorandum of understanding which will include subject recommendation. This is a priority item to the involved parties, and while it is realized that complete agreement may not be reached by all the states, it is anticipated that some minimum guidelines will be agreed to by nearly all of the participants.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to develop a fraud unit training manual incorporating the most effective techniques and methods for dealing with Medicaid provider fraud based on the experience gained by the fraud units.

Departmental Comment

We concur. A fraud unit training manual has been under discussion for some time. Various training seminars have been conducted at which literature, based on the experience of effective fraud units, has been disseminated. This type of literature will ultimately become part of a draft for a training manual. The development of this manual will commence as additional staff are added to the division administering the program.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to reassess the adequacy of the fraud unit agreements now in effect in those States where the attorney general's office does not have statewide prosecution authority or if it does, the unit is located outside that office, to assure that prosecution can be carried out as needed statewide.

Departmental Comment

We concur in part with GAO recommendation that the Inspector General reassess the adequacy of the relationship between the units and outside prosecutors. A draft is presently being disseminated among affected organizations that would require, for the first time, agreement with local prosecutors having jurisdiction over a substantial part of the State's provider community--not all local prosecutors. We hope to publish a notice of proposed rulemaking in the near future.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to decertify those State fraud units that fail to meet the statewide prosecution requirement of the law and regulations.

Departmental Comment

We concur with GAO in principle that those States that fail to meet the statewide prosecution requirement of the law and regulations should not be certified. However, we disagree with GAO interpretation of the applicable regulations. The regulations require that if there is no State agency with statewide prosecution authority the unit must establish "formal procedures which assure that the unit refers suspected cases of criminal fraud in the Medicaid program to the appropriate State prosecuting authority or authorities" (see 42 CFR 455.300(d)(2)). There are presently no requirements in the statute or regulation for an agreement with local prosecutors. However, see above.

GAO Recommendation

That the Secretary of HHS direct the Inspector General of HHS to issue guidelines on the essential elements that should be included in the fraud unit formal procedures with local prosecutors and working relationships with the State attorney general to assure statewide prosecution of fraud cases.

Departmental Comment

We concur with GAO recommendation. We are preparing draft regulations to amplify these requirements.

(106173)